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Using narrative ideas to learn about mental illness in the classroom

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Abstract

Narrative ideas provide an interesting basis for teaching health practitioners. The specific notions discussed here have been referred to as reflecting teams and as outsider-witness practices. These practices involve offering feedback in non-evaluative ways as a means of exploring new possibilities and perspectives for participants. The emphasis is on the acknowledgement and resonance that occurs when a story is told and witnessed through connecting the story with the lives of the listeners. This paper offers an example of classroom work linked to students' assignments that was designed to help general nursing students learn about people with mental health problems. The assignments focused on the media representations of people with a mental disorder. The notions of reflecting teams and outsider-witnesses were used in a classroom exercise to witness the stories described in the assignments. The primary aim was to help students to develop richer understandings of people with mental health problems that might lead to more caring ways of practising nursing. The reflecting team process helped students to go beyond the media stereotypes of mental illness and the people who suffer from it. It promoted new understandings of mental health consumers. The exercise enabled students to learn more about stigma and its undermining influence on peoples' lives, to pay close attention to their own language use, and to commit to an enhanced advocate role for vulnerable groups in their care in future practice settings.

Keywords

Mental illness, peer learning, narrative practice

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This paper offers an example of classroom work linked to students' assignments that was designed to help general nursing students learn about people with mental health problems. The assignments focused on the media representations of people with a mental disorder. The notions of reflecting teams and outsider-witnesses were used in a classroom exercise to witness the stories described in the assignments. The primary aim was to help students to develop richer understandings of people with mental health problems that might lead to more caring ways of practising nursing.

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Background

The idea of narrative and storytelling has found favour in the literature as a means of undertaking research and as a learning device. It has become central to the caring professions as a means of engaging professionals and students in ethical concerns and issues (Fairburn 2002). However, Paley and Gail (2005) noted some inconsistencies and offered some points of clarification in the use of the terms narrative and story.

My own interest in narrative practices is drawn from narrative therapy (Morgan 2000; White 2000; White and Epston 1990). In this literature the terms narrative and story are used interchangeably. As I learned more about the features of narrative practices in therapeutic settings I came to appreciate more fully their potential in the mental health field (see Hamkins 2005) and in particular how I might use some of these ideas in teaching nursing students about mental health.

The two core ideas I intend to discuss here have been described as reflecting teams (Andersen 1991) and as outsider-witness practices (Fox, Tench and Marie 2003). These practices provide a means of giving feedback in non-judgemental ways to help elicit new possibilities and perspectives for clients and therapists. I have been part of outsider-witness reflecting teams and have observed firsthand the transformative potential for those involved in this practice in therapeutic settings.

These ideas were used in a classroom context and linked to students' assignments. The assignments were designed to help general nursing students learn about people with mental health problems in society. In this example, I have adapted reflecting team and outsider-witness processes in the teaching of general nursing students undertaking the Bachelor of Nursing degree in an Australian university. The primary purpose was to explore the potential use of these ideas borrowed from narrative therapy for promoting greater understanding and acceptance of people with mental health problems in practitioners of the future.

An essential challenge for educators is to engage nursing and other health care students in ways that move them 'beyond diagnosis' (Harper et al 2007). Indeed, the move away from a diagnosis and medication model of care has been raised as a challenge for established health practitioners (Bentall 2009). The starting point here was to acknowledge that many students learn about mental illness and people who are distressed through media sources. Indeed, mental illness is a common theme in a wide range of media in spite of the fact there has been a growing voice of discontent with the ways in which these media sources portray people with mental illness (Wahl 1995). Media representations of the people who suffer from mental illness in movies and other media are important sources of information and education for all members of society including nursing and other health care students.

During periods of clinical placements, opportunities for students to meet with and care for people with mental health issues may be opportunistic and constrained by short placements and in acute settings. On many occasions, students' views are established and maintained through no real experience at all. Many students rely on community level exposure via the media to learn about people with mental illness and those who care for them.

The Bachelor of Nursing degree in Australia leads to a generic registered nursing qualification (RN). There are no specific 'branches' leading to specialisation in mental health or other areas. Students can experience a number of clinical placements and learn about older people with dementia or people who are anxious, depressed or even suicidal. These clinical experiences provide students with a rudimentary introduction to mental health care and encounters like these are often framed within a general nursing setting.

General nursing students studying a mental health unit for the first time often feel 'anxious and scared about the potential dangers' of this area. These attitudes are more pronounced if they are undertaking a practical placement in a mental health setting. The way students speak about the subject initially frequently reflects views typically observed in media portrayals. They refer to people in distress as 'patients' and seek to label patients as 'psychotic schizophrenics' or as 'neurotic' and as 'unpredictable and

dangerous'. These descriptions are in stark contrast to the Australian practice context where people receive treatment as mental health 'consumers', 'clients' or as 'sufferers'.

Describing peoples' lives

Morgan (2000: 2) described narrative therapy as a

> respectful, non-blaming approach to counselling and community work, which centres people as the experts in their own lives. It views problems as separate from people and assumes people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives.

The narrative therapy approach is one in which the professional helper works as a collaborator, rather than an expert, helping the client to see themselves as separate from the problems in their lives, and working to pinpoint times when they were not harassed by these problems. The narrative approach has become an essential aspect of family therapy and is developing an emerging influence in mental health also (Carr 1998).

In many cases the stories people tell helpers about their lives and identities are very limiting and diminishing — 'I'm a schizophrenic' or 'I'm a depressive type of person'. Such 'thin' descriptions of the person's life offer little room for movement and change. Often these descriptions become influential in explaining everything about that person and their view of themselves. A person may come to understand themselves through thin descriptions, which lead to

> thin conclusions, drawn from problem-saturated stories, [which] disempower people as they are regularly based in terms of weaknesses, disabilities, dysfunctions or inadequacies. (Morgan 2000: 13)

However, thin descriptions always exclude some aspects of lived experience (Payne 2000). It can be described as changing emphasis in their own therapeutic narrative practice according to Freedman and Combs (1996: 16):

> bring forth and thicken … stories that did not support or sustain problems … As people began to inhabit and live out the alternative stories, the results went beyond solving problems. Within new stories, people could live out new self images, new possibilities for relationships and new futures.

Changing the emphasis onto 'thick' or rich story description in a therapeutic context has significant potential for engaging mental health clients through having a sense of hope and working to re-establish a person's identity as capable of achieving appropriate recovery goals (Roberts 2000). Instead of emphasising the problem-laden accounts of peoples' lives which stem from thin descriptions, thick descriptions open up the possibilities for health care staff to elicit the full richness of a client's lived experience, with a clear emphasis on the talents, competencies and achievements that were hidden (Watkins 2001).

Using narrative ideas to challenge students' views

Like other members of the community, nursing students learn about mental illness through the popular media. Many of these media portrayals can be classed within a narrative framework as 'thin' descriptions of peoples' lives. Yet these are powerful in shaping students' attitudes, beliefs and feelings about people who are mentally ill and how they might interact with them. However, narrative ideas also furnish us with ways to make possible real changes in students' thinking through developing thick and rich descriptions of peoples' lives.

Many students approach the study of mental health in their Bachelor of Nursing degree with a rather thin and poor understanding of mental illness, those who experience mental distress, its impact on the lives of people and on the lives of those who care for them. This is revealed in the language they use and in the attitudes and beliefs they hold initially. The aim of the classroom exercise outlined below was to help the students to develop a deeper understanding of the people who experience mental distress. Richer understandings provide a basis for taking a more hopeful and empowering approach as a professional student helper.

Eliciting thick descriptions

Members of a reflecting team (professionals and trainees) usually observe a therapy session from behind a glass window and comment on what they heard and observed (Andersen 1991). These comments tend to be speculative and not as interpretations or judgements (Andersen 1987). However, White (1995) described a sense of unease about using professional reflecting teams (such as the emphasis on pathologising and power). Instead he used Myerhoff's (1986) 'definitional ceremony' metaphor to describe how people come to see and bear witness peoples' worth and identities. He used this to describe outsider-witness practices.

At some point in therapy when people are ready to develop new and rich stories about their identities and preferred ways of living, an audience of outsider-witnesses may be invited to listen to the person's story and reflect on this. The role of the audience (often a family or other people important to the client) is to help the person to 'make space for an alternative story to emerge' (Roberts 2000: 437).

The outsider-witness team is not a group of 'experts'; instead members need to avoid making interpretations, offering advice or praising peoples' achievements (Payne 2000). Their purpose is to accept the legitimacy of the person's experiences and by so doing 'provoke people's fascination with certain of the more neglected aspects of their lives' (White 1995: 180). Outsider-witnessing is described by White (2004) as a practice of acknowledgment in which elements of the story resonate with the audience.

In this exercise, the reflecting team approach and some of the ideas from an outsider-witness process were adapted to the classroom. I hoped that this adaptation of the reflecting team might help to challenge the 'supremacy of expert knowledges' (White 1997), often found in students. Stories that emerged about people with a mental illness from the students' assignments were shared in a tutorial setting as an approximation of a client narrative. These were then processed using outsider-witness questioning. This process is described below.

A story is evoked through assignment writing

People with mental illness are frequently portrayed as violent and dangerous (Allen and Nairn 1997) in spite of the contrasting evidence (Mullen 1997). Other negative stereotypes such as criminality, vulnerability (linked to incompetence), unpredictability and harmfulness to self have been reported (Coverdale, Nairn and Claasen 2002). These contribute to the formation of societal views and may undermine attempts at community inclusion. According to Hannigan (1999), these negative images may seriously reduce the quality of life of people with mental illness and infiltrate professional attitudes too (Hocking 2003).

The small group of students (n=8) who took part in this tutorial exercise were completing a mental health study unit in the third year of a three and a half year Bachelor of Nursing degree and were undertaking a clinical placement in mental health. The students were invited to explore some of the themes and issues from their mental health assignments using the outsider-witness processes. I requested consent from the student group to publish ideas from the tutorial process that may be helpful to others learning about mental health. The group was fully supportive of this.

The enthusiasm with which the group embraced the activity was enhanced by several factors, which helped to establish a safe high-quality learning environment. (1) They were familiar with my teaching style, which was challenging yet supportive and often entailed trying new things and different ways of thinking about their work. (2) The students worked well together as a group over the semester and there was a foundation of trust where each could share things about their lives and feel comfortable doing so. The culture and value of peer learning within the group was fostered and developed in tutorials generally. (3) Members of the group also trusted me and recognised my commitment to the issues of wellbeing in students and consumers alike and the respectful way that I approach my work. Near the end of the semester one of the students commented: ‘We never know exactly what will happen in your class Paul but it’s always worth coming because we learn things all the time’. (4) Students were invited to partake in the activity in the knowledge that what would occur was wholly in keeping with the approach taken up to that point in the semester even if the structure was a little different. (5) Invitations by professors to take part in an exercise may be influenced by power relationships. However I had taken these students for a different subject the previous year and they were familiar with my approach to work so the relationship that was established was not unduly shaped by power and status but by mutual respect.

Students were asked to write a paper on media representations of people who experience mental illness selecting materials from television, radio, cinema, plays, magazines, photographic images, tabloid and broadsheet newspapers, advertisements and so on. The main aim was to help students develop a critical awareness of how the media influences peoples’ attitudes, beliefs and perceptions of those who are mentally ill. The assignment required students to identify important issues and analyse their impact on people in society. The assignment gave students the opportunity *to tell a story* about the way people with a mental illness are depicted in the popular media and to consider this as future health professionals.

A story is told and re-told

The students were brought together in a small group format and invited to recount some of the things they found in preparing and writing their assignments. These stories were shared (a telling) by each member of the group, while other students assumed the role of members of a reflecting team to the story telling (Fox et al 2003). They were then asked to reflect on and re-tell the story they heard by addressing a small number questions.

This process often leads to new segments of meaning being added to the narrative. Three basic stages to this process were described by White (1997): a telling, a re-telling (by the outsider-witness group) and a reflection by the storyteller. Each student was required to take a storytelling role by speaking about what they wrote in their assignment and to be a member of the outsider-witness group reflecting on the accounts offered by other students.

People are often touched by the stories they hear in particular ways. However when questions about stories are framed around certain categories of response as described by White (2006), stories or bits of the stories can *resonate* with the audience in very personal and moving ways. White (2006) described four core categories of response to a story as follows: (1) identifying the expressions or images; (2) describing the image; (3) embodying responses; and (4) acknowledging transport. The questions used to explore the reflections of outsider witnesses were framed within these categories.

A further clarification about the process of responding as a witness to a story was offered by White (2006: 13):

> The responses of outsider witnesses are not shaped by contemporary practices of applause (giving affirmations, pointing out positives, congratulatory responses, and so on) — or for that matter, any of the common and routine practices of judgement.

The outsider witness process is about *acknowledging* peoples' lives or particular facets of their lives.

The reflection and re-telling process was structured by a number of key questions drawn adapted from Stringer et al (2003), as shown in Table 1. These shaped the structure of the activity and allowed a much richer story of the lives of people with a mental illness to unfold. The questions were presented to students in class and they were asked to write down their individual responses to these. The responses were shared within the group afterwards. The questions were designed to provide a form of 'scaffolding' to assist the students to 're-tell' something of the stories they heard. The written responses to these were typed up and constructed into a group narrative by me as a co-author while staying true to the students' own words and phrases.

A summary of this group narrative is provided below under the headings of: (1) acknowledgement, (2) resonance, (3) personal change, (4) learning and (5) future work. This summary of the group narrative reflects a much richer understanding of the lives of people who experience mental illness elicited from the students' stories and their reflections on these. The summaries illustrate how a much thicker description of the lives of people with mental illness can be arrived at and shared and how this may *resonate* with students preparing to work with people with a mental illness. However,

Table 1: Questions for members of outsider-witness group.

1. As you listened to the assignment stories described by members of the group which particular images or expressions caught your attention or struck a chord for you?
2. What did these images or words suggest to you about the lives of people with mental illness and their carers?
3. What is it about your own life or work that explains why these images caught your attention?
4. Where has the experience of completing this assignment and the reflecting team exercise taken you?
5. What have you learned from completing the assignment and the reflecting team process?
6. What will you take with you into the future as a result of doing the assignment and this tutorial exercise?

this exercise is exploratory and is a first trial of its potential as an educational tool. A more detailed account of the summaries is available in a separate paper (see Morrison 2009).

(1) Acknowledgement

The process of sharing stories based on assignment work allowed the students to tap into specific aspects of the lives and identities of people with mental illness and to *acknowledge* these or certain aspects of these more fully. Students' attention was drawn to the stigmatised identity that shapes the lives of many people with a mental illness and those who care for them. They made reference to the way people with mental illness responded to the stigma and the shame linked to the illness. The process of acknowledging the powerful impact of stigma meant taking on board the role of health professionals in supporting this stigmatised identity. People with a mental health problem who come into contact with health professionals have been referred to as 'unpopular' patients and treated accordingly (Kelly and May 1982; May and Kelly 1982; Johnson and Webb 1995).

In spite of the rhetoric of holistic care, this group continues to be stigmatised health care consumers. Corrigan and Kleinlein (2005) documented the impact of mental illness stigma on peoples' lives and highlighted the negative reactions of the health care system resulting in a poorer standard of general services for people with a comorbid mental disorder. In a review of consumer stories of stigma Angell et al (2005) highlighted the paternalistic and coercive care provided by mental health professionals. This attitude resulted in a general sense of dehumanisation, being treated like a child and low expectations and hopelessness. The approach described here may provide a constructive framework for addressing this shameful issue.

Students also recognised and acknowledged the strong feelings of intense depression and loneliness that consumers feel. They began to understand peoples' need to fit in while seeing life as a constant struggle through adversity. However it was noted how in spite of the fact that many people with a mental illness struggle they still find it difficult to accept help from others. They acknowledged the sense of disheartenment and little hope that is common in consumers' lives.

(2) Resonance
The process of acknowledging fully the difficult lives of people with mental illness elicited a *resonance* within the student group. Resonance is about understanding why the students were drawn to some aspects of the stories and how these *connected* with their own values, personal interests and histories (White 2007). Some students revealed the fact that they already knew people with mental health problems in their personal lives and they began to see and appreciate these lives differently.

The resonance with consumers' lives achieved through the reflecting team exercise helped them to acknowledge and talk about their own personal difficulties and struggles. It also helped students to admit to the existence of personal feelings of depression yet feel confident enough to share this with others in the group. Students began to see consumers as ordinary people with ordinary lives (just like themselves) and recognised the dehumanising effects of psychiatric diagnostic labels. There was new appreciation of the social distance that professionals often put between themselves and those in their care — especially when these involve a psychiatric diagnosis. They reflected on how hard it might be to be perceived as an outsider in society, how they might respond differently to people and families in a professional context and how they might begin to approach their work differently.

(3) Personal change
The students recognised how the group process helped them to achieve a greater level of understanding and acceptance of people with a mental illness. They felt a heightened sensitivity and openness and a reduced fear of people with mental illness. Some students felt that the completion of the assignment and later reflecting on it in this format would change the way they interacted with others at home as it brought out a more critical awareness of the influence of media on adults and children. While there is some evidence that changes in media representations are occurring, we still have some way to go. A study of portrayals of mental health and illness in Australian non-fiction media by Francis et al (2004) found that reporting of mental health and illness was wide-ranging and of good quality generally. Surprisingly there was less emphasis on the topics of crime and violent behaviour — issues that can shape community attitudes in a negative fashion.

However, Crowley-Cyr and Cokley (2005: 64) offered a scathing analysis of the language used by journalists reporting on mental health issues when framed within ethical codes of practice and concluded 'journalism is not as yet worthy of the title "profession"'. In addition mental health consumers are now approaching media representations with a new 'postpsychiatry' voice. In a very recent paper Holland et al (2009) describe this emerging perspective which highlights the consumer or survivor with a greater sense of personal agency offering very detailed and distressing personal accounts of care in public media arenas. It refers to a process of consumers 'talking back' on *their* terms about *their* experiences.

Some students felt that they would be more compassionate in a professional context. They commented on how the process evoked a new appreciation of the value of friends and family members in their own lives and a recognition that they were not alone in this world.

(4) Learning

The students identified a number of areas where learning occurred including how to address the dehumanising effects of stigma at work and at home and to be more accepting of human frailty. They also highlighted the importance of becoming an independent thinker and to avoid simply following the crowd expressions of fear and distain towards people with a mental illness — often found in professional settings too (Kelly and May 1982). They hoped to become even more aware of the tricks used by the entertainment industry and how they use ill people to entertain. Paying attention to these ploys such as the use of music, images, language and labels to evoke fearful associations could help them to challenge these in their personal lives and as health professionals in working groups.

The group activity provided opportunities for peer learning. Papinczak et al (2007) explored the use of peer assessment within a problem-based learning approach in a medical degree. One of the standout issues to emerge was students' concern about the negative impact peer evaluations may evoke in a learning group. The group work explored here was not an evaluative one, yet the structure of the activities enabled students to offer perspectives on the accounts provided by each member of the group so that the understanding resulting from multiple perspectives was richer and shared by all who took part. This type of understanding helped students to learn about themselves and others in the group and the emphasis was more on peer-assisted learning than evaluation. Huijser et al (2008) describe how peer-assisted learning may also be fostered in online learning settings and this outsider witness framework would lend itself to that mode of delivery.

(5) Future work

Students were able to identify some of the ways in which a new understanding could be put to use in future practice settings. These centred on their intentions to seek out rather than avoid people who may be frail and in distress, to better manage their own anxieties and to accept themselves and their lives more fully. Being more self-aware and having a fuller understanding of mental illness will help students to approach people who may be troubled with mental health issues.

Students also identified the need to monitor their own language use when discussing people who have experienced mental health problems. Students became aware of the language used in general settings where 'difficult' patients can be labelled and treated accordingly. The 'difficult patient' label is very common and is sometimes synonymous with having a mental health problem. It is also used in mental health settings to refer to patients who are hard to treat and who fail to adhere to the wishes of the staff. The term 'difficult' can be stigmatising and can imply that patients are responsible for their own ill health in some way. Nor does the term suggest possibilities for effective treatment or care.

Finally students intended to advocate more fully for vulnerable people in their care. As beginning practitioners this is quite an undertaking. Fitting into a new and established work setting where experienced staff may be dismissive of people with mental health problems can be a daunting experience. However approaching a new work setting with the intention of being an advocate is commendable and highly desirable as without these intentions change is unlikely. It would very interesting to hear how these intentions were realised.

Conclusion

The classroom exercise described here helped students to move from 'thin' descriptions of the lives of people with a mental illness, which are often negative and diminishing, to 'thick' or rich descriptions of peoples' lives. Thin descriptions are very noticeable during the assessment process when people come into contact with health services. Watkins (2001) compared the assessment of clients to an 'archaeological' dig with an over-emphasis on finding the cause of the problem. Such approaches rarely provide clues to helping with clients' current distress. The symptom orientation found in assessments is often ritualised. White (1997: 50) called this approach

> a thin narrative of a person's lived experience [which has] become the defining story. The more often it is told, the more the person comes to see himself as a problematic person, living a problematic life.

On the other hand thick descriptions of peoples' lives tend to elicit new perspectives and possibilities for the future. These new and rich descriptions provide new options and ways of helping people who have experienced mental illness within a particular tradition of care and treatment.

The classroom exercise elicited a much richer description of the lives of people with mental illness, one that could be more fully understood and acknowledged by students and linked with their own lives and professional identities. It provided an interesting and imaginative means of engaging and challenging students by providing a scaffolding for moving away from known and familiar views to a new understanding of themselves and an acknowledgement of the lives of people who experience mental distress.

The exercise also helped students to prepare for the real world of practice with a heightened sensitivity and an awareness of their own vulnerability. It challenged the students' attitudes, views and beliefs about mental illness and those who suffer from it. It enabled students to approach their work with a more positive and hopeful attitude and intentions to interact with and advocate for people with a mental illness.

Freedman and Combs (1996) have argued forcefully for a more positive emphasis on possibilities for change in place of the emphasis on diagnosis. This is an area where nurses can advance to a more therapeutic role in the future. The application of reflecting team and outsider-witness processes drawn from the field of therapy provides a framework for enhancing understanding of mental illness and those who experience it and in so doing, helps to create opportunities for developing a more helpful approach in practice.

In this instance, students' assignments were used to tell a story to reflect on. However, there are many excellent written accounts of peoples' experiences that could be used as narrative sources for reflection such as *Bird's Nest Soup* (Greally 2008), *9 Highland Road* (Winerip 1994) and *Is There No Place On Earth for Me?* (Sheehan 1983).

Finally, the approach outlined may also be useful in the development of clinical supervision activities with clinical practitioners who may not wish to specialise in mental health care but who will inevitably confront people with mental health problems at work.

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